Healthworks Therapy & Nutrition Center, Inc.

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgment

Other (Please Specify)

_____

_____

_____

Dr. Jill M. Hutter D.C. 3525 S. Tamarac Dr. #215 Denver, CO 80237 P. (303) 779.4878 F. (303) 779.4894

Consent Form To Chiropractic

Chiropractic focuses on the nervous system and spinal cord. During chiropractic treatment, the doctor will use his/her hands or a mechanical device in order to align your spine to correct interference to the nervous system and improve the body's ability to control and coordinate many functions. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joint, or injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment.

The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of stroke has been estimated at one in a million to one in twenty million, and can be even further reduced by screening procedures.

I, _____, understand the hazards and potential dangers involved in treatment by means of chiropractic. I believe that this treatment is in my best interest and I understand that no guarantee of results has been made.

I understand that it usually requires a series of chiropractic treatments to significantly change a condition and receive benefit.

My signature indicates that I have read and fully understand the above information regarding the consent to this procedure. I have had the opportunity to ask questions about any matter which I did not understand, and I have received satisfactory explanations to my questions. My signature below authorizes this procedure.

_____	_____	_____
Patient/Authorized Representative Signature	Relationship to Patient	Date

Practitioner Statement: The patient (or patient's representative) and I have discussed this procedure, the risks and alternatives to this procedure. To the best of my knowledge, the patient (or patient's representative) understands this procedure and consents to it.

_____	Jill M. Hutter, D.C.	_____
Practitioner Signature	Practitioner Printed Name	Date

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WELCOME! PLEASE PRINT.

** Please allow our staff to photocopy your driver's license and all available insurance cards**

PATIENT INFORMATION:

Full Name_____ Gender: ☐ **M** ☐ **F** Age_____ Birth Date_____

Address _____ City _____ State _____ Zip _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated** Number of Children: _____

Social Security #: _____ Driver's License #: _____

Home Phone (___)_____Work Phone (___)_____Cell Phone (____)_____

What is the best number to contact you? ☐ Home ☐ Work ☐ Cell E-mail _____

Employer _____ Occupation _____

Business Address_____ City _____ State _____ Zip _____

Whom may we thank for referring you? _____

Describe the major complaints that bring you to our office: _____

_____

Is your condition due to an accident? ☐ Yes ☐ No Date of your accident: _____

EMERGENCY CONTACT:

Name _____ Home Phone (___)_____

Address _____ City _____ State _____ Zip _____

PRIMARY INSURANCE:

Do you have health insurance? ☐ Yes ☐ No

Insurance Company _____ Member I.D. #: _____

Insurance Company Address _____ City_____ State ____ Zip _____

Group #: _____ Plan #: _____

Person Responsible for Account _____ Date of Birth _____

Relationship to Patient _____ Social Security #: _____

Spouse's Employer_____ Occupation_____

Spouse's Work Address _____ City _____ State____ Zip _____

Insurance Company _____ Work Phone(___)_____

Insurance Company Address _____ City _____ State ____ Zip _____

Insurance Company Phone (_____)_____ Member I.D. #: _____

Group #: _____ Plan #: _____

If you have secondary insurance, please submit a copy of your insurance card to our staff

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Please answer the questions below concerning you health history. Be sure to list all conditions or symptoms, both past and present.
An understanding of your health history will help us to determine appropriate care.

Review of Systems

1. Do you have skin, hair or nail problems? ☐ Yes ☐ No
2. Do you have nose and/ or sinus problems? ☐ Yes ☐ No
3. Do you have ear problems? ☐ Yes ☐ No
4. Do you have eye problems? ☐ Yes ☐ No
5. Do you have chest or lung problems? ☐ Yes ☐ No
6. Do you smoke? ☐ Yes ☐ No
7. Do you have heart and/ or blood vessel problems? ☐ Yes ☐ No
8. Do you have blood or nymph node problems? ☐ Yes ☐ No
9. Do you have digestive problems? ☐ Yes ☐ No
10. Do you have genital problems (e.g. prostate, testicular, vaginal)? ☐ Yes ☐ No
11. Do you have urinary (including kidney or bladder) problems? ☐ Yes ☐ No
12. **Females**, have you had menstrual problems? ☐ Yes ☐ No
    Have you ever taken birth control pills? ☐ Yes ☐ No
    Is there any chance that you are currently pregnant? ☐ Yes ☐ No
    Do you have any breast problems? ☐ Yes ☐ No
13. Do you have any nervous system diseases and/ or mental health problems? ☐ Yes ☐ No
14. Do you have any gland and/or hormone problems? ☐ Yes ☐ No
15. Do you have allergy or immunity problems? ☐ Yes ☐ No
16. Do you have any muscle, tendon or ligament problems? ☐ Yes ☐ No
17. Do you have any bone or joint diseases (ex. Bone= osteoporosis, joint= arthritis)? ☐ Yes ☐ No

Past History

18. List any diseases which you have had in the past, including childhood diseases: _____
    _____
19. Tell us if you have ever been diagnosed as having a particular condition such as diabetes, cancer, AIDS, etc. _____
    _____
    _____
20. Have you suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, laceration, sprains, strains, dislocations, broken or cracked bones? ☐ Yes ☐ No
    _____
    _____
21. List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):
    _____ Date_____
    _____ Date_____
    _____ Date_____
22. Have you ever been hospitalized for any reason other than surgery? ☐ Yes ☐ No
    _____
    _____

(OVER PLEASE)

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23. **Medications:** Please list all medications (prescription & non-prescription) you are currently taking of take on an occasional basis:_____

_____

24. Your diet is: ☐ Balanced ☐ Fair ☐ Poor ☐ Excessive ☐ Restricted

Family History

25. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions)?
☐ Yes ☐ No _____

Social History

26. In what position do you usually sleep, and how well? _____

_____

27. Do you exercise on a regular basis? ☐ Yes ☐ No How?_____
28. How do you spend you spare time (hobbies, etc.)? _____
29. Do you use: ☐ Caffeine ☐ Tobacco ☐ Nicotine ☐ Recreational Drugs ☐ Alcohol
30. Please describe your work.
Type: ☐ Professional ☐ Physical Labor ☐ Driver ☐ Clerical ☐ Factory ☐ Homemaker

Physical Demands: ☐ Heavy ☐ Moderate ☐ Mild ☐ Sedentary

Stress Level: ☐ High ☐ Medium ☐ Low

Additional Questions

31. Do you have problems with recurring headaches? ☐ Yes ☐ No_____
32. Are you losing weight without trying? ☐ Yes ☐ No_____
33. Does your pain wake you up at night? ☐ Yes ☐ No_____
34. Have you had a change in bowel or bladder habits? ☐ Yes ☐ No_____
35. Have you had a sore that doesn't heal? ☐ Yes ☐ No_____
36. Have you recently had any unusual bleeding or discharge? ☐ Yes ☐ No_____
37. Do you have a thickening/lump in the breast or elsewhere? ☐ Yes ☐ No_____
38. Do you have digestion or difficulty swallowing? ☐ Yes ☐ No_____
39. Have you had an obvious change in a wart or a mole? ☐ Yes ☐ No_____
40. Do you have a nagging cough or hoarseness? ☐ Yes ☐ No_____
41. In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history which was not requested, please fill it in below. _____

_____

_____

_____

42. Who is your:
Medical Doctor?_____

OB/GYN? _____

Dentist? _____

I (we) agree to pay for the services rendered to the above mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for the professional services rendered to me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and her staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case manager, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of a consequence thereof. I agree that a photo static copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/ chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photo static copy of this agreement shall serve as the original.

I (we) understand that a service charge of $50.00 for missed appointments may occur if 2 hours prior notification of cancellation does not occur.

Patient's Signature_____ Date _____

Spouse's or Guardian's Signature _____ Date _____

We file your primary insurance at no charge to you. Filings for policies in addition to your primary coverage are completed for a fee and as time permits.